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MEDICAID BULLETIN

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CCC Plus Claims Processing

The purpose of this bulletin is to provide clarification of the 2019 Commonwealth Coordinated Care (CCC) Plus contract provisions regarding third party liability (TPL) claims processing for commercial payers and Medicare crossover claims. Please share this information with all operations/system configuration, care coordination, network/provider relations and customer service staff who work with the CCC Plus Medicaid program and/or population. This bulletin addresses the most frequently asked claims questions submitted to DMAS and is not an all-inclusive list. Please refer to Attachment 4 at the end of this bulletin for details on the DMAS Coordination of Benefits Agreement (COBA) Claim Exclusion List.

Definitions:

- Coordination of Benefits (COB) refers to the adjudication of Medicaid clean claims when Medicare or Commercial insurance is the primary payer.
- Clean claim, as defined in the CCC Plus contract, refers to a claim that has no defect or impropriety (including lack of required and substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim under this title.
- Patient responsibility as described in this document refers to copayments, coinsurance, and deductibles identified by the plan. Medicare plans do not have copayments amounts; however, commercial and Medicare Advantage (MA) plans may have copayment amounts identified for members.
- Crossover claims only refer to Medicare claims and identify patient responsibility

  (coinsurance and deductibles) that are “crossed over” for payment by Medicaid also known as Medicare’s “billed charges.” For the purposes of COB, MA and Dual Eligible Special Needs Plans (D-SNP) follow traditional Medicare processing rules and are included in the definition of crossover claims.

Payment Processing:

- The Medicaid Managed Care Organizations (MCO/Contractor), as payer of last resort, are responsible for coordinating all benefits covered under the CCC Plus Contract. When the primary payer is a commercial MCO, the Contractor is responsible for the full copayment amount.
- MCOs must reimburse copayments indicated by primary commercial and MA plans in its entirety. Commercial patient responsibility of coinsurance and deductibles, identified on Explanation of Benefits (EOB), is not considered

when processing the claim for payment. The MCOs must process these claims based on the commercial payment amount and the Medicaid or MCO allowable/contracted rate.

- For covered healthcare services and supplies, the Medicaid allowable/contracted rate refers to the allowed amount located in the fee schedule or provider's contract with the MCO.
- Medicaid is payer of last resort and sequestration must be accounted for when adjudicating claims.

1. DME Claims (Crossover / Commercial COB for CMS-1500/837 Professional (P) Claims)		
IF	**THEN**	**Source**
Medicare (MCR) Billing Unit **≠** Medicaid (MCD) Billing Unit (e.g. DME Rentals: Oxygen Rental Supply, CPT Code E0431 RR. MCR Billing Unit = 1 month MCD Billing Unit = 1 day)	MCO Reimburses[1] the Indicated Medicare Patient Responsibility (PR)	**2019 CCC Plus Contract Attachment 15 – Coinsurance** *'Medicaid payments are made when the reimbursement from the primary insurance amount was less than what Medicaid would reimburse for the **exact unit amount and procedure code**.' Some services or supplies, such as DME rental supplies, have differing billing units; therefore, MCOs would reimburse the full co-insurance and deductible indicated by Medicare.* **For further clarification, review DMAS guidance sent to MCOs third quarter FY19 (see attachment one (1) page 6)**
MCR Billing Unit **=** MCD Billing Unit	MCO Reimburses the Difference when the MCD Allowable or MCO Contracted Rate **greater than Medicare Paid up to billed amount**	**2019 CCC Plus Contract Attachment 15 & 16**
MCR Billing Unit **=** MCD Billing Unit	MCO Does Not Reimburse when the MCD allowable or MCO Contracted Rate **less than Medicare Paid**	
Primary Commercial **=** COB Claim	MCO Reimburses[2] the Difference when the MCD Allowable or MCO Contracted Rate **greater than Commercial Paid**	
Primary Commercial **=** COB Claim	MCO Does Not Reimburse when the MCD allowable or MCO Contracted Rate **less than Commercial Paid**	

1. Without calculation
2. MCO must disregard commercial coinsurance/deductible; however, indicated copayments must be paid in full. This applies to services/supplies regardless of billing unit match, etc.

2a. Skilled Nursing Facility Crossover Claims – Part A			
IF	**AND**	**THEN**	**SOURCE**

MCR Claim has Crossover Patient Responsibility	MCD Claim = MCR RUG to MCD RUG crosswalk calculation	MCO Reimburses the Difference when the MCD Allowable or MCO Contracted Rate[1] **greater than Medicare Paid up to billed amount**	**2019 CCC Plus Contract Attachment 15 & 16**
MCR Claim has Crossover Patient Responsibility	MCD Claim = MCR RUG to MCD RUG crosswalk calculation	MCO Does Not Reimburse (edit 364) MCD Allowable or MCO Contracted Rate **less than Medicare Paid**	**For further clarification review SNF Part A presentation conducted Friday, February 15, 2019 (See attachment two (2) examples on pages 7 – 11)**

1 Patient pay, as identified by the Department of Social Services (DSS), must be applied if entire patient pay has not already been deducted on another claim for the month of service.

2b. Nursing Facility Crossover Claims – Part B Therapy (PT, OT, SL-P) Services Only		
IF	**THEN**	**SOURCE**
MCR Claim = Crossover PR	MCO Reimbursement[1] = Indicated Medicare PR	**Email to MCOs: Friday, January 19, 2018 (See attachment three (3) on page 12)**

1 Without calculation. This is due to the MCO allowable rate must be set to the Medicare allowable rate for Part B NF therapy claims. This does not reference all Part B crossover claims such as telehealth services.

3. NCCI Edits (MUE / PTP) and Medicare Secondary Claims (CMS-1500/835P Claims)		
IF	**THEN**	**SOURCE**
MCR Claim Applies NCCI Edits	MCD Claim DO NOT apply NCCI Edits	**2018 Medicaid NCCI Technical Guidance Manual pgs. 9-10 (<- embedded link)**

4. Early Intervention (EI)[1], Addiction Recovery and Treatment Services (ARTS), Community Mental Health and Rehabilitation Services (CMHRS), Waiver Services		
IF	**THEN**	**SOURCE**
Service = EI, ARTS, CMHRS, Wavier	MCO Rate = MCD fee schedule rate[2]	**2019 CCC Plus Contract 12.4.2**

1. Certain EI Services must be cross walked to the appropriate Medicaid Procedure Code
2. When the MCO is the primary payer, claims must be reimbursed at the Medicaid rate which may exceed the billed amount. MCO reimbursement for MCR crossover claims or COB commercial claims must be reimbursed at the Medicaid rate even if the primary payer's EOB indicates payment in full.

5. Primary Payer Non-Covered or Denial of Service		
IF	**THEN**	**SOURCE**
Service is not a covered service by MCR or Commercial Payer (e.g. LTSS waiver services)	MCO cannot require EOB denial of service[1] from primary payer	**2019 CCC Plus Contract 12.4.12.3**
Service is covered by MCR or Commercial BUT MCR or Commercial payer denies service	MCO may reimburse as primary payer AND pursue payment from primary MCR/Commercial payer -OR- MCO can choose to deny as primary payer requesting provider exercise due diligence including, but not limited to, exhausting appeal process with primary MCR/Commercial payer (e.g. denials for no service authorization or medical necessity)	**2019 CCC Plus Contract Attachment 15**

6. DMAS and COBA Claim Exclusion for MCOs Only[1]		
IF	**THEN**	**CLAIM TYPES**
MCR Claim = Paid in full or Denied (e.g. hospice service)	DMAS does not receive MCR claims (Optional for MCOs)	**See Attachment Four (4) on page 13 for list of DMAS selected claim exclusions**

Attachment 1 (Page 6): Part B Processing Clarification for Therapy Services Billed by Nursing Facilities

Attachment 2 (Page 7): DMAS SNF Part A Nursing Facility Presentation

Attachment 3 (Page 12): DME Rental Supplies Crossover Claims Processing Clarification **Attachment 4 (Page 13):** DMAS COBA Claim Exclusion List

Medicaid Expansion

New adult coverage begins January 1, 2019. Providers will use the same web portal and enrollment verification processes in place today to verify Medicaid expansion coverage. In ARS, individuals eligible in the Medicaid expansion covered group will be shown as "MEDICAID EXP." If the individual is enrolled in managed care, the "MEDICAID EXP" segment will be shown as well as the managed care segment, "MED4" (Medallion 4.0), or

"CCCP" (CCC Plus). Additional Medicaid expansion resources for providers can be found on the DMAS Medicaid Expansion webpage at: http://www.dmas.virginia.gov/#/medex.

PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal Automated Response System (ARS) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-forservice members.	https://dmas.kepro.com/
Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or call: 1-800-424-4046
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627

ATTACHMENT ONE: PART B PROCESSING CLARIFICATION FOR THERAPY SERVICES BILLED BY NURSING FACILITIES

Please reference the following DMAS clarification provided to all MCOs on January 19, 2018 regarding the payment methodology of Part B crossover claims for therapy services (physical therapy, occupational therapy, and speech and language

therapy).

Attention Health Plans –

The following provides clarification regarding the DMAS payment rate for therapy services billed by nursing facilities for dual-eligible Members. Different from the crossover claim payment method for most other services, ***Medicaid currently pays up to the Medicare allowable for these therapy services when billed by a nursing facility****. We have also confirmed that these amounts are included in the CCC Plus health plan (nursing facility) capitation rate.*

We recognize that while this payment method is not clearly defined in the CCC Plus Contract; the Contract requires that the MCOs pay nursing facility claims at no less than the DMAS Medicaid payment rate. For this reason, CCC Plus plans must pay the Medicare Part B crossover claims up to the Medicare allowable for therapy services billed by nursing facilities.

ATTACHMENT TWO: DMAS SNF PART A NURSING FACILITY PRESENTATION

Please reference the following presentation examples of SNF Part A Nursing Facility cross over claim payment methodology presented by DMAS on February 15, 2019.

EXAMPLE ONE: RUG PRICING ONE LINE

Example One: Components

Example One: Calculation

EXAMPLE TWO: RUG PRICING MULTIPLE LINES

Example Two: Components

Example Two: Calculation

EXAMPLE THREE: PRICING FIRST 21 DAYS OF CROSSOVER

Example Three: Components

Example Three: Calculation

EXAMPLE FOUR: EDIT 0364

Example Four: Components

Example Four: Calculation

EXAMPLE FIVE: EDIT 0364

Example Five: Components

Example Five: Calculation

ATTACHMENT THREE: DME RENTAL SUPPLIES CROSSOVER CLAIMS PROCESSING CLARIFICATION

The following is clarification sent by DMAS to all MCOs during the third quarter of FY19 regarding the payment methodology for DME Rental Supply crossover claims.

As stated in the July 13, 2018, DMAS memo addressing Clarification on Coordination of Benefits with Medicare and Other Insurance, coinsurance is

reimbursed by the MCO'…when the reimbursement from the primary insurance amount is less than what Medicaid would reimburse for the ***exact unit and procedure code***

There are instances in which the Medicare and Medicaid billing unit and/or procedure code differ, such as oxygen and wheelchair DME rentals. In these instances, Medicare requires one (1) unit for the entire month (or portion thereof) and Medicaid's fee schedule indicates a per diem rate. Because the ***billing units differ****, Medicaid does not have a comparable reimbursement rate and the MCOs would reimburse the co-insurance and deductible*

Medicaid Fee-for-Service would reimburse the crossover claim with the full co-insurance and deductible indicated by Medicare because the units are ***not equivalent****. MCOs should process these cross over claims in the same manner that Medicaid Fee-for-Service processes cross over claims.*

ATTACHMENT FOUR: DMAS COBA CLAIM EXCLUSION LIST

DMAS Fee-for-Service (FFS) maintains a coordination of benefits agreement (COBA) with the Centers of Medicare and Medicaid Services (CMS) to coordinate benefits for dually enrolled Medicare and Medicaid members. There are certain claims, listed below, that DMAS FFS has excluded from receiving as cross over claims from Medicare due to the nature of reimbursement, e.g. original Medicare claim paid in full without patient responsibility remaining. These claims are also known as informational claims from Medicare. MCOs may elect to exclude the same types of claims in their COBA agreement.

1. Original Medicare claims fully paid without deductible or coinsurance remaining
2. Adjustment claims fully paid without deductible or coinsurance
3. Original Medicare claims paid at greater than 100% of submitted charges without deductible or coinsurance remaining
4. 100% denied original claims, with no additional beneficiary liability
5. 100% denied adjusted claims, with no additional beneficiary liability
6. 100% denied original claims, with additional beneficiary liability
7. 100% denied adjusted claims, with no additional beneficiary liability
8. Adjustment claims, monetary (see 10 below to also exclude only Medicare Physician Fee Schedule {MPFS} updates)
9. Adjustment claims non-monetary/statistical (see 11 below to also exclude non-monetary mass adjustments)
10. Mass adjustment claims tied to MPFS updates (monetary in nature)

11. Mass adjustment claims – other (could be monetary or non-monetary in nature)
12. Medicare Secondary Payer (MSP) claims (to globally exclude MSP paid or denied claims)
13. MSP cost-avoided (fully denied) claims
14. All adjustment claims
15. Recovery Audit Contractor (RAC) claims

Process for MCOs to modify receipt of informational COBA claims

- MCOs will need to complete the COBA-Attachment found on the CMS website and indicate on the form claims they do not wish to receive. To obtain the instructions and attachments, follow the **CMS** (<-embedded) link.
- MCOs will need their unique COBA ID to complete the form.
- MCOs are required to mail the completed form along with a cover letter indicating COBA claims change request to the Information Management Division of DMAS.
- The Agency Director will send signed request to CMS with MCO change request.
- CMS will then contact the MCO by email to confirm the change request, perform testing and, place into production.